DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2008 FORM APPROVED OMB NO. 0938-0391

		(X1) PF:OVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDFINTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		09G203	B. WIN	1G			6/2008	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X8) COMPLETION DATE	
W 104	State Agency (SA Unusual Incident that revealed that (ATS) #1 witness right hand and more than the SA conducte 10, 2008 to verify standards of practice of the facility's tandards of practice determined that A administrative least approximately 1:4 investigation substand ATS #2 has terminated from the results of the interviews with C administrative standards and the facility's adminicident reports. 483.410(a)(1) GC The governing bedy and open the standard open than the standard	at approximately 7:45 PM the was notified via facsimile of an Report (UIR) from the facility. Active Treatment Specialists ed ATS #2 squeezing Client #1's buth. Id an on-site investigation on July compliance with the basic citice and federal participation are Conditions of Governing Body attion. The investigation are was placed on ave on July 7, 2008 at 42 PM. The facility's internal stantiated the allegation of abuse been scheduled to be employment. It investigation were based on lient #1, ATS, nursing and aff. Also the findings were based the client's medical record, and inistrative records; including DVERNING BODY and must exercise general policy, rating direction over the facility.		104	GOVERNMENT OF THE DIST DEPARTMENT OF HEALTH REGULATION A 825 NORTH CAPITOL ST., WASHINGTON, E	HEALTH DMINISTRATION N.E., 2ND FLOO	1	
ABORATOR	operating direction following areas:	on over the facility, except in the	NATURE		10 hot. Al	JR S	(X8) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days foll of the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 day date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09 G2 03	B. WI	٧G			C 6/2008
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC				601	ET ADDRESS, CITY, STATE, ZIP CODE 10 DIX STREET, NE ASHINGTON, DC 20019	L . 	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 149	The finding include Cross refer to W14 to provide sufficient ensure the implement management policy allegations of abus administrator. 483.420(d)(1) STAI CLIENTS The facility must de policies and proced mistreatment, negle This STANDARD Based on interview facility's staff failed management proto investigation (Clien The finding include On July 9, 2008 at Unusual Incident R was reviewed and Specialists (ATS) # #2, physically abus Client #1's right ha Interview with the L on July 10, 2008 at revealed that appro 6:00AM and 6:15A informed her that A The LPN statd that that she did not dis	9. The governing body failed administrative oversight to entation of its incident involving reporting all eximmediately to the EF TREATMENT OF evelop and implement written lures that prohibit ect or abuse of the client. Is not met as evidenced by: and record review, the to implement it's incident col for one of one client in the t #1).		149	This standard will be met as Evidenced by: Review of record indicates that facility currently has written pol procedures regarding abuse/ne mistreatment. A team efforts has been utilized senior management (Director of Residential Services, Assistant Director of nursing, RN's Incide Manager and Training Department) to retrain all staff i area of abuse/neglect, incident and Bill of right. The facility will ensure that all i are reported to pertinent agency/management in accord district law and that confirmatic is file on client record/incident book. The facility management/Traini department will continue to tra an on-going basis and will ensincident of abuse/neglect or mistreatment are thoroughly investigated in accordance wistandard. Any employee that facomply with this standard as swill be subject to disciplinary as	The licies and eglect and d by the first continuation of the reporting incidents ance with on report report ing ain staff on sure all ith ails to set forth	7/10/2008

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EXAMENT OF DESICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI		G	(X3) DATE SL COMPLE	TED
		09G203	B. WIN	IG _		1	6/2008
	ROVIDER OR SUPPLIER	, INC	·	6	REET ADDRESS, CITY, STATE, ZIP CODE 010 DIX STREET, NE VASHINGTON, DC 20019	<u> </u>	37 2 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BE	(X5) COMPLETION DATE
W 149	Further interview of the the LPN did not involving Client #1 Interview with ATS approximately 6:4: witnessed ATS #2 squeezing Client ##1 stated that on LPN and the ATS Further interview or report the alleged 9:00AM on July 7, the alleged abuse Interview with the 2008 at approxima July 7, 2008 at apparrived on duty, A and observe ATS ATS Shift Leader ATS #2 physically Shift Leader state and that Client #1 bruises on her bothat on July 7, 200 report the alleged anyone. Review of the Incident #1 pruises on July 7, 200 and 4:40 PM revealed witnesses, discov Reportable Incident immediate suffacility staff on during interview of the Incident immediate suffacility interview of the Incident immediat	evealed that on July 7, 2008, of report the alleged abuse	W	149	W149 This Standard will be met as Evidenced by: All staff received training on July 2008. In addition, facility management continue to train staff in an on-g basis to ensure compliance with reporting procedures as written.	y 10, will oing	7/10/2008

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		·	A. BUILDIN	· · · · · · · · · · · · · · · · · · ·		c
		09G203	B. WING			6/2008
	ROVIDER OR SUPPLIER IAL DEVELOPMENT	INC	(REET ADDRESS, CITY, STATE, ZIP CODE 8010 DIX STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 149	Continued From pa	age 3	W 149		<u> </u>	
W 153	nursing staff imple management polic 483.420(d)(2) STA CLIENTS The facility must end mistreatment, neglinjuries of unknown immediately to the	ence that the facility's ATS and mented it's incident y in a timely manner. FF TREATMENT OF Insure that all allegations of ect or abuse, as well as a source, are reported administrator or to other noce with State law through dures.	W 153	W153 This standard will be met as evidenced by: Disciplinary action has been to the employees involved in to report incident as outline policies and procedures. In addition, staff has receive	given failure in the	8/20/2008
	Based on interview failed to ensure that	is not met as evidenced by: y and record review the facility at all allegations of abuse are ely to the administrator.		additional training in the ar policies and procedures as o by the agency and DDS. The facility management/Tr department will continue to reinforce this policy by provon-going training in this are:	utlined aining iding	
W 159	approximately 7:45 was notified via fact Report (UIR) from Active Treatment S ATS #2 squeezing mouth. The incider reported to the adrimmediately. 483.430(a) QUALI RETARDATION P Each client's active integrated, coordinates.	49. On July 7, 2008 at 5 PM the State Agency (SA) csimile of an Unusual Incident the facility that revealed that Specialists (ATS) #1 witnessed Client #1's right hand and not of alleged abuse was not ministrator or to the SA FIED MENTAL ROFESSIONAL The treatment program must be nated and monitored by a stardation professional.	W 159	Evidence of such training wi filed inside the training book facility.	in the	

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SYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G203	B. Wil	NG		1	C 6/2008
	ROVIDER OR SUPPLIER JAL DEVELOPMENT,	INC		60	EET ADDRESS, CITY, STATE, ZIP CODE 110 DIX STREET, NE (ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BE	(X5) COMPLÉTION DATE
W 159	This STANDARD Based on interview Qualified Mental Re (QMRP) failed to a and coordinate the one of one client in The findings includ 1. Cross refer to Wensure that Active and nursing reporte immediately to the 2. Cross refer to Wensure that ATS ar continuing training the facility's incider reporting all allegathe administrator. 483.430(e)(1) STA The facility must pr initial and continuin employee to perfore efficiently, and con This STANDARD Based on staff inter facility failed to ensibeen provided with the employee to perfore effectively, efficien The finding includ Cross refer to W14	is not met as evidenced by: If, and record review, the etardation Professional dequately monitor, integrate, health and safety needs for the investigation. (Client #1) e: If 53. The QMRP failed to Treatment Specialists (ATS) ed all allegations of abuse, administrator. If 89. The QMRP failed to and nursing staff received to enable them to implement at management policy on tions of abuse immediately to IFF TRAINING PROGRAM Tovide each employee with and training that enables the IFF that is or her duties effectively, inpetently. Is not met as evidenced by: erviews and record reviews, the sure that each employee had a adequate training that enables erform his or her duties erform his or her duties tity and competently. es: 49. The facility staff had not	W	159	W159 This Standard will be met: Evidenced by: The QMRP/Director of nur, incident manager and train department has complete trall staff to ensure that all distaff /nurses are trained in incident reporting, abuse/mand individual bill or rights In addition, The QMRP will ensure that direct care staff adequate training to perform effectively, efficiently and competently.	rsing ning raining of irect care areas of eglect i.	7/10/2008
		49. The facility staff had not ained to implement the facility's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SI IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G203	B. WING			C 6/2008
	ROVIDER OR SUPPLIER	, INC	601	ET ADDRESS, CITY, STATE, ZIP CODE 10 DIX STREET, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	ALL B. BE	(X5) COMPLETION DATE
W 189	incident managem	age 5 ent policy on reporting all se immediately to the	W 189	W189 This Standard will be me Evidenced by: Cross Reference W149	t as	7/10/2008
				·		
		·				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1''	E CONSTRUCTION	(X3) DATE S COMPL		
			A. BUILDING		•	С	
		HFD03-0207		B. WING		07/1	6/2008
ME OF PROV	IDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	DEVELOPMENT,	INC	6010 DIX WASHING	STREET, NE STON, DC 200	019		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENC	LIES	io	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	YMUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	(E APPROPRIATE	COMPLETE
1 000 IN	ITIAL COMMEN	TS		1000			
St. Ur tha (A	ate Agency (SA) nusual Incident R at revealed that A	approximately 7:45 was notified via factleport (UIR) from the Active Treatment Spect ATS #2, squeezing mouth.	esimile of an le facility pecialists		0		
Julia lic in or ap in	ally 10, 2008 to version to version to the version of the version of the version and the version and the version of the versio	an on-site investigerify compliance with y requirements. The mined that ATS #2 eave on July 7, 2002 PM. The facility's tantiated the allegate has been schedumployment.	h the State e was placed 8 at internal		GOVERNMENT OF THE DEPARTME HEALTH REGULAT 825 NORTH CAPITO	ENT OF HEALTH FION ADMINISTRA	TION
in ad ba re	terviews with Clie dministrative staf ased on the revie	investigation were lent #1, ATS, nursin f. Also the finding wo of the client's medity's administrative reports.	g and s were edical				
1 379 3	519.10 EMERGE	ENCIES		1379			
e H u ir a p	ach GHMRP sha lealth, Health Fac nusual incident o iterferes with a re irrangement, well laces the resider se made by telepl	reporting requiremental notify the Departiculation of a prevent which subsessident's health, will being or in any other at risk. Such notification with the postification will be a postification with the postification will be a postification will	ment of ny other stantially velfare, living ner way fication shall and shall be				
		itten notification wit lours or the next wo					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NO			A. BUILDING		(X3) DATE S COMPL		
		HFD03-0207		B. WING	 _		16/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, 5	TATE, ZIP CODE		
INDIVIDU	JAI. DEVELOPMENT,	, INC		STREET, NE STON, DC 20	019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
I 379	GHMRP shall notif Health Facilities Di incident or event w with a resident 's h arrangement, well places the resident be made by teleph followed up by writ twenty-four (24) ho The finding include On July 9, 2008 at Unusual Incident F 2008, was reviewed Treatment Special witnessed ATS #2	met as evidenced by the Department of vision of any other untrick substantially intreath, welfare, living being or in any other that risk. Such notification within ours or the next work es: approximately 4:00 I Report (UIR) dated Jured and revealed that a lists (ATS) #1 reported, physically abusing I Resident #1's right ha	Health, nusual erferes way ation shall be day. PM an anuly 7, Active edly Resident	1379	3519.10 This Statue will be me evidenced by: Cross Reference W10 W153 and W159		7/10/2008
	on July 10, 2008 a revealed that appr 6:00AM and 6:15A informed her that #1 1. The LPN sta #1 and that she di scratches or bruis or mouth. Further 7, 2008, the the LI abuse involving R Interview with ATS approximately 6:4 witnessed ATS #2 by squeezing Resmouth. ATS #1 si	Licensed Practical Nat approximately 2:00 roximately between the AM on July 7, 2008, A ATS #2 was "fighting atd that she assessed of not discover any swes to Resident #1's rinterview revealed the PN did not report the esident #1 to anyone 5 #1 on July 11, 2008 5 AM revealed that she are the province of the province o	PM ne hours of ATS #1 " Resident I Resident welling, ight hand hat on July alleged 3 at ne esident #1 and 2008, she				

Health Regulation Administration

incident. Further interview revealed that ATS #1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIF IDENTIFICATION NO. (X1) PROVID		UMBEK:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SI COMPLE COMPLE	TED	
	ROYIDER OR SUPPLIER		STREET ADDR 6010 DIX S' WASHINGT	FREET. NE	ATE, ZIP CODE		
(X4) ID PREFIX TAG	A CALL DE ELCIEN	TATEMENT OF DEFICIENC CY MUST BE PRECEDED LSC IDENTIFYING INFOR	DIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIATE	(X5) COMPLETE DATE
1379	did not report the Resident #1 until time she reported Facility Coordina Interview with the 2008 at approximuly 7, 2008 at a arrived on duty, and observe AT ATS Shift Leader ATS #2 physica Shift Leader stabody and that Rhave any bruise revealed that or Leader did not Resident #1 to Review of the July 1, 2003 or 4:40 PM reveal witnesses, discrete Reportable Incomust immediate facility staff on Reportable Incompany staff in the resident	alleged abuse involence of the alleged abuse tor (FC). ATS Shift Leader of the alleged abuse tor (FC). ATS Shift Leader of the alleged abuse to (FC). ATS #1 requested the area of the alleged abusing Resident to the alleged abusing the abusing Resident #1 was not the alleged abuse alleged abusing the alleged abuse to the alleged abusing Resident #1 was not the alleged abuse involved the alleged abuse to the alleg	to the on July 11, aled that on M when she hat she come ent #1. The d not witness i #1. The ATS sident #1's observed to her interview TS Shift ouse involving of Policy dated eproximately who d of a Serious this policy, he incident to r on duty. The orts of Serious r, 7 days a acility's ATS andent				